UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
REGION 19

COMMUNITY HEALTH CENTER LA CLINICA

Employer

And Case 19-RC-14551

UNITED STAFF NURSES UNION, UFCW LOCAL 141, UNITED FOOD & COMMERCIAL WORKERS INTERNATIONAL UNION, AFL-CIO

Petitioner

REGIONAL DIRECTOR'S DECISION AND DIRECTION OF ELECTION

Upon a petition duly filed under Section 9(c) of the National Labor Relations Act, as amended, a hearing was held before a hearing officer of the National Labor Relations Board, hereinafter referred to as the Board. Pursuant to the provisions of Section 3(b) of the Act, the Board has delegated its authority in this proceeding to the undersigned. Upon the entire record[1] in this proceeding, the undersigned makes the following findings and conclusions.[2]

SUMMARY

The Petitioner filed the instant petition seeking a unit of professional employees, including physicians, physician assistants, nurse practitioners, certified nurse midwife, registered dietician, behavioral health specialists and registered nurses, with the usual exclusions (the "Unit").[3] The Employer raises three contentions in response to the

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[1] The Employer filed a timely brief, which was duly considered.

[2] The hearing officer's rulings made at the hearing are free from prejudicial error and are hereby affirmed. The Employer is engaged in commerce within the meaning of the Act and it will effectuate the purposes of the Act to assert jurisdiction herein. The labor organization involved claims to represent certain employees of the Employer and a question affecting commerce exists concerning the representation of certain employees of the Employer within the meaning of Section 9(c)(1) and Section 2(6) and (7) of the Act.

[3] The Petitioner amended the petition during the hearing to include in the professional unit "all regular full-time, part-time and per diem positions, physician assistants, nurse practitioners, nurse midwifes, behavioral health specialists and registered dietitians, employed at the Employer's Kennewick Medical facility located at 5219 West Clearwater, Suite No. 6, Kennewick, Washington, and those employed at the Employer's Pasco Medical facility located at 525 West Court Street, Pasco, Washington." The record and the Employer's brief persuade me that the

petition. First, the Employer contends that its licensed physicians, "disciplinary leads," RNs, RN leads, and the Kennewick lead are statutory supervisors and, thus, should be excluded from the Unit. Second, the Employer contends that its physicians are managerial employees who should be excluded from any unit found appropriate. Third, the Employer contends that the Unit is inappropriate because there is nothing to distinguish inclusion of the professional employees in social/support services from the Employer's other professional employees, the latter of whom neither the Petitioner nor the Employer seek to include in the Unit. According to the Employer, the only appropriate unit must be one limited to the professionals on the "clinical, medical side of the house."

Based on the record as a whole and the parties' respective briefs, I find that the Employer's physicians, disciplinary leads, RNs, RN leads, and the Kennewick lead are not statutory supervisors. I also find that the physicians and their leads are not managerial employees. Thus, I shall include physicians, physician leads, RNs, RN leads, and the Kennewick lead in the Unit. Additionally, I find that the social/support service employees share a sufficient community of interest with Unit employees to warrant their inclusion in the Unit.

Below, I have set forth a section dealing with the evidence, as revealed by the record in this matter, relating to (1) background information; (2) general information about the Employer's operations; (3) particular information about the Employer's medical clinic operations and the roles played by the physicians and RNs and their respective leads in the clinics; and (4) evidence relating to Unit employees working in the Employer's social/support service operations. Following the Evidence section is a restatement of the parties' positions, my analysis of the applicable legal standards in this case, and my conclusion, decision and direction of election.

I.) EVIDENCE

A.) Background Information

The Employer is a State of Washington non-profit corporation located in Southeastern Washington; where it is engaged in the business of providing an array of health and social services to the public.[4] The Employer utilizes seven facilities in three cities in providing its services. The Employer's five Pasco, Washington, facilities house its "Detox" Center, mental health center, dental clinic, self-help housing operation, and "main" operation. Six miles to the south, the Employer's only Kennewick, Washington, facility houses a medical and dental clinic. Thirty-six miles to the north,[5] in Basin City, Washington, is the Employer's North Franklin Social Services Center where one (nonprofessional) outreach person is stationed. In all, the Employer employs approximately 300 employees and services 28,000 to 29,000 clients. At issue are the

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Petitioner also intends to include in its petitioned-for unit, the Employer's physicians and registered nurses employed at the same locations.

[4] The non-acute health care nature of the Employer's operation is not at issue. Indeed, it is evident from the record that the Employer is not a health care facility within the meaning of Sec. 2(14) of the Act.

[5] This distance is a driving miles estimate from Mapquest.

Employer's medical clinic employees in Kennewick and the medical clinic and support services operation employees located in its main building in Pasco.[6]

The parties stipulated to the professional status of the following petitioned-for employees: approximately 13 medical doctors/physicians (MDs), 1 certified nurse midwife (CNM), 14 registered nurses (RNs), 5 physician's assistants (PAs), 5 advanced registered nurse practitioners (ARNPs), 3 behavioral health specialists (BHSs) and 1 registered dietician (RD). The Employer presently employs at least 40 non-professional employees in the medical clinic and support services at the Kennewick and Pasco main building -- these 40 employees are not at issue herein.

B.) <u>The Employer's Operations</u>

The Employer provides medical, dental, social or support,[7] behavioral health and self-help housing services to the general public and specializes in providing these services to the Spanish speaking community. The Employer has a board of directors, but administratively, John Troidl, the Executive Director, heads the operations on a day-to-day basis. Reporting to him are the Administrative Manager (an open position as of the time of the hearing) and Brad Hinton, the Controller. Additionally, reporting to Troidl are the Directors of Housing, Operations, Human Resources, and Clinical Services.

The Employer provides medical care through its medical clinical/services program, in these four areas of care: internal medicine, family practice, OB/GYN and pediatrics. The Employer has a medical clinic located at its "main" facility in Pasco, where it offers all these services, and another medical clinic at Kennewick where it offers internal medicine, OB/GYN services, and family practice services.

An Employer witness, James Arthurs, MD, is head of Clinical Services, of which the medical clinics are a part. Presently, Arthurs, in addition to his clinical services duties, is also performing the duties of the Medical Director, a vacant position administratively falling directly under the Director of Clinical Services. The Dental, NECCS and Pharmacy Directors also report directly to Arthurs.[8] Presently, since Arthurs is also Acting Medical Director, the petitioned-for physicians, as well as the clinics' "mid-levels" (ARNPs, CNM, PAs and PA-Cs)[9] report to him (the Employer contends that the physicians and mid-levels at the Pasco clinic report to "leads" of the

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[6] Not at issue but also located on the first floor of its Pasco main building is the Employer's medical and X-ray laboratory.

[7] The terms "social services," "support services," and "maternity social (or support) services" have been used interchangeably throughout the record.

[8] NECCS or Nueva Esperanza Community Counseling Services offers mental health services. The Pharmacy Director position was vacant at the time of the hearing in this matter.

[9] The ARNP, CNM, RD, PA and PA-C positions are collectively known as mid-level positions since their education and certifications allow them to perform more medical procedures than RNs but less than those performed by MDs. The difference between the PA and PA-C positions is that the occupant of a PA-C position is certified by the State of Washington, while those in the PA position are not. The position descriptions for the PA and ARNP positions are identical. However, testimony indicates that of those in these positions, medics mostly gravitate to PA and PA-C positions while RNs gravitate to ARNP positions.

different medical disciplines,[10] who in turn report to Arthurs). George Thomas, the Clinical Services Manager also presently reports directly to Arthurs in the latter's capacity as Acting Medical Director. The clinical lab and the Nursing Manager, Maria Mendez,[11] both located at the "main" facility, report directly to Thomas. Mendez heads the Nursing Department wherein eight of the petitioned-for RNs are organizationally located.

Presently reporting to Arthurs is Ernie Segren, PA, who is the "lead" for the Kennewick medical clinic. Also located at the Kennewick medical clinic are 2 MDs, 2 RNs, one CNM and one PA-C, whom, along with Segren, the Petitioner would include in the Unit.

The petitioned-for support services professionals—4 RNs, 3 BHSs and the RD—also work in the same building as the Pasco medical clinic employees, albeit in a separate section of the same building. Moreover, the support services professionals also have a separate reporting structure than that of the Pasco and Kennewick medical clinics. In this regard, Richard Ballard, Support Services Manager oversees Support Services professionals and he reports to the Director of Operations, who, in turn, reports to Executive Director Troidl.[12]

C.) The Employer's Medical Clinic Operations

The Employer's medical clinic program offers primary care to the public within the disciplines of family practice, internal medicine, pediatrics, obstetrics and gynecology (OB/GYN). The providers (MDs and mid-levels) of this care fall into one of these disciplines. The Nursing Department also divides itself along the same discipline lines as the providers.

1.) Physicians (MDs)

The physicians and midlevels are licensed by the State of Washington and provide adults with medical care, e.g., physical exams. They also provide pregnant women with clinical medical services during all stages of their pregnancy and delivery.[13] Salaries for the Employer's MDs range between $110,000 and $218,000 a year.

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[10] E.g., internal medicine, family practice, OB/GYN, and pediatrics. The physicians/MDs and the midlevels are also collectively referred to as the "providers" in the context of providing medical care to patients visiting the clinics.

[11] The parties referred to the Nursing Manager's name as Maria Mendez at the hearing. However, the organizational chart identifies her as Maria Mendez Campos.

[12] Clinical Services Director Arthurs, Nursing Manager Mendez, Clinical Services Manager George Thomas and Internal Medicine Medical Director George Vargas are the only 2(11) supervisors stipulated to by the parties. While there is no stipulation, neither of the parties contends that Executive Director Troidl and Support Services Manager Ballard should be included in the Unit. In view of the above and the record as a whole, I shall exclude Arthurs, Mendez, Thomas, Vargas, Troidl and Ballard from the Unit, as they possess indicia of supervisory authority as that term is defined in Section 2(11) of the Act.

[13] Virtually all the evidence presented on the Employer's medical clinical operation was confined to how the Pasco medical clinic operated.

The mid-level providers operate pretty much independently of the physicians.[14] Like MDs, they can write prescriptions; order X-rays, ultrasound, pregnancy and urinalysis tests; make diagnoses; refer patients; and order immunization shots and IVs, which are performed by RNs or HCAs. The Employer pays the mid-level providers between $55,000 and $75,000 a year. The Employer maintains that all licensed physicians are statutory supervisors in that they assign, responsibly direct, hire or effectively recommend hiring, evaluate, and/or discipline employees.[15]

a.) Assign & Responsibly Direct

MDs are responsible for the health care and treatment of their patients, even if they delegate their responsibilities to an RN or HCA. While record testimony indicates that this responsibility may emanate from the MDs' State of Washington licenses and/or certifications, there is no evidence in the record that the Employer likewise independently holds the MDs responsible for health care work that they might delegate to HCAs. In particular, the Employer submitted no evidence showing that the Employer has disciplined or evaluated MDs in connection with their alleged authority to assign and responsibly direct employees. Indeed, Dr. Zolessi, a MD in the Pasco medical clinic, testified that there was nothing unique about his employment relationship with the Employer that made him more responsible for the duties that are being carried out by others. Further, the parties did not submit any employee handbook or documents describing the Employer's policies on such responsibility.

With regard to the discipline of MDs, the record reveals that employees may file "incident reports" against an Employer MD if the MD provides questionable care. However, these incident reports are not indicative of whether the Employer holds the MDs responsible for the care provided by others employed by the Employer. Rather, the use of incident reports by the Employer appears to provide an avenue for an employee to alert his or her supervisor that an incident of note has occurred. Indeed, incident reports can be written by anyone about anyone, including by CNAs about MDs and midlevels. There is no evidence that these incident reports lead to discipline affecting an MD's terms and conditions of employment. For example, the record discloses that an incident report was filed against Dr. Vargas by an unnamed "supervisor" who alleged that Vargas had not used "the right way." Testimony did not elaborate what "way" was being challenged. In any event, Vargas testified that he wrote to the Employer's human resources department in response to the incident report and defended his course of action. The Employer did not submit additional evidence regarding whether any action had been taken as a response to the incident report filed against Vargas or whether this incident had anything to do with the assignment and/or responsible direction of employees.

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[14] Even though the MD position description shows that MDs may be required to sponsor PAs, pursuant to State of Washington regulations, testimony indicates that PAs at the clinic operate independently of physicians.

[15] It appears the Employer effectively concedes that midlevels are employees rather than statutory supervisors or managers. In this regard, the Employer did not submit evidence or argument in support of a contention that they are supervisors or mangers. Under these circumstances and in light of the record as a whole and the Employer's arguments, I shall include the midlevels in the Unit. See *Staco*, 244 NLRB 461, 461-62 (1979).

In another instance, the Medical Director, Dr. Arthurs, was presented with an incident report written by an unnamed employee against an unnamed MD. According to testimony, the report, which was not submitted by the Employer into the record, relayed a patient's concern over "documentation." Dr. Arthurs sought out another MD, Dr. Zolessi, to have him review the record and report back. After Dr. Zolessi found a missing "dictation," Dr. Arthurs testified that he and Dr. Zolessi came to the decision that no discipline was warranted. There was no evidence that the alleged offending event concerned patient care. Moreover, no discipline was issued and, although Dr. Zolessi was not asked about this particular incident on the record, he testified that he has never disciplined anyone.

Dr. Arthurs, after receiving another incident report "on a patient complaint," sought out another MD, this time Dr. Delgado, for his professional perspective on the issue. In that instance, Delgado's "information" helped Dr. Arthurs understand the concerns of the particular area of medical practice involved, and, according to him, both he and Dr. Delgado came to an agreement on the proper discipline. However, the record does not elaborate on the nature and extent of this "agreement" beyond Dr. Delgado's providing of information to Dr. Arthurs.

With respect to MDs' work with nurses, the record reveals that MDs may direct nurses and/or HCAs to prepare for patient examinations by setting up the proper equipment needed in the examination. The MDs may also order X-rays or other tests performed on patients and may order such procedures as removal of post-operative stitches, provision of wound treatment, injections, IVs, patient monitoring, and other regular patient examination procedures such as obtaining vital signs, blood pressure, weight and pulse readings. The work performed by the RNs and HCAs in this regard is work for which they have received training and for which they are licensed. Such work is performed by the RNs and/or HCAs on a routine and daily basis in the Employer's clinics.

At times, a provider (MD or mid-level) will give specific instructions to an RN or HCA for treatment of a particular patient, such as whether and what gauge to give an IV and whether a cardiac patient needs an ambulance, nitro, or aspirin. Other than these types of emergencies, the provider's instructions on how to perform such duties are limited either to new employees or to taking corrective action if an RN or HCA incorrectly provides care to a patient.

One RN, called by the Union to testify, asserted that she often receives her tasks from the nurse's station rather than directly from an MD. Some of the tasks assigned to nurses at the nurse's station in the clinic are distributed in the order in which the tasks come into the station. The record did not elaborate much further on the role of the nurse's station in distributing tasks or MDs' orders to the nurses.

One MD testified that generally patients are taken to an examination room where their vital signs are taken before the MD arrives. From there, the MD reviews the patient's history, performs a physical examination, arrives at a diagnosis, prescribes treatment, care, medication, and/or orders necessary lab testing -- following this, the MD testified that protocols or procedures then take over. For example, any necessary immunizations are prescribed by the applicable protocol(s). Regarding shots, an MD further testified that he has not administered a shot or performed an IV on a patient for about 6 years as those functions have been historically performed by the nurses and the

MD was not aware of any other MDs performing such tasks in the Employer's operations. Indeed, the MD testified that he was not comfortable performing IV work, as he had not performed such a procedure in over 6 years.

With regard to protocols, the record reveals that correct "protocols" or procedures for administering healthcare to patients are kept in Employer computers that are readily accessible by all the Employer's employees. In this regard, Dr. Vargas, a stipulated supervisor, testified that the protocol, which RNs or HCAs may access, is simply "copy" from authoritative sources, such as books, on the appropriate care. In particular, Vargas testified, "My sister, an interior designer, [can] go into the computer and do the same thing that I can do, get that protocol from the computer and the nurses can do that. So my input into that is just to say copy this from a book…. You know, we're not researcher people that are creating anything new in medicine. It's established, you follow or you follow because it's been something that was created by people well recognized in the area…"

The protocols referred to by Dr. Vargas are national protocols that were discussed in discipline committee meetings for adoption by the Employer. The committees are chaired by "discipline leads"[16] and these committees will consider the protocols pertinent to that medical discipline or practice. Once a committee formulates its recommendation on the proposed adoption of a national protocol, the recommendation of the committee is forwarded onto Dr. Arthurs for his approval. According to Dr. Arthurs, speaking about these committees, "They can be asked to be participatory in creating a policy or amending a policy, if conditions have changed, and the input from those providers is vitally important in terms of how, at least, the clinical piece of that policy is to be carried out." There is no evidence that the committees establish protocols or recommend policy beyond the "clinical piece" of a policy. Moreover, the "participatory" role of these committees was not detailed with regard to what if any significant impact they may have on the formulation and/or implementation of Employer policies.

With respect to work schedules for nurses, the record reveals that the Nursing Department is responsible for assigning the nurses to specific providers. The record reveals that MDs' work schedules, aside from the on-call schedule, are dictated in large part by the their patients' need to be seen by the MDs. In this regard, patients call the Employer's coordinator who schedules the patient.

With regard to the providers' on-call schedules, the Clinical Director testified that Lorena Mayuga, a "clinical lead" (MD), "had some participation just individually in making the call schedule for all of the medical disciplines." According to Arthurs, Mayuga communicates with the Employer's medical service office so that she will be aware of

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[16] The Employer, at hearing, referred to "discipline leads" and in its brief, also referred to them as "clinical leads." However, testimony from one of these "discipline leads" revealed that this term is unknown to MDs; rather, the "discipline leads" see themselves as chairmen. As chairmen, they chair committee meetings and write up agendas for the meetings. However, the "chairs" who testified stated that they have no authority over the participants in the meeting and that employees not in the chair's field or practice are also allowed to participate, and have done so. According to the chairs, the committees have no authority to change policy; they can only recommend a protocol be adopted or amended and Dr. Arthurs has the final say on a protocol's adoption or amendment.

vacation times. Additionally, she takes "input" from clinical leads and providers and creates a monthly on-call list. The Clinical Director further testified that the on-call schedule is in response to "the responsibility that all of us providers have to our patients and the liability of not providing that, as well as the responsibility of fulfilling the staff privileges for those providers as part of their hospitals requiring that they take call[s]." The record, however, does not provide concrete evidence regarding the nature or extent of input that the MDs and mid-levels provide Mayuga, how that input factors into the on-call schedule, or regarding the nature and extent of Mayuga's "participatory" role in the on-call schedule.

If a MD requests time off from work, he or she can submit, to a "lead," a form detailing the time involved. According to Dr. Arthurs, the approval for granting time off is based on the number of MDs left, the patient load, and an Employer policy on mandatory minimums for the number of providers needed to be present at a clinic. According to one of the leads, the leads will check the schedule to see if the criteria are met and will sign off on the request and forward it to Dr. Arthurs. If the criteria are not met, the "lead" asks the provider whether he or she can change the time they are requesting off. If the provider will not change the request, the "lead" signs the request anyway and forwards it to Dr. Arthurs. Dr. Arthurs will then independently check the schedule to see if the requested time meets the set criteria. Dr. Arthurs states that he has "overruled" leads in their "approvals" 2 to 3 times in the last month, but the leads are usually correct 75-80% of the time.[17]

In sum, the record reveals no evidence to establish that the Employer holds the MDs responsible for directing employees either by way of evaluations of the MDs' performance and/or by way of disciplining MDs in connection with an alleged responsibility to direct employees. Indeed, there are no evaluations or discipline of this nature in the record.

b.) <u>Hiring/Effective Recommendation of Hiring</u>

In his hiring of new providers, Dr. Arthurs employs a hiring team consisting of providers, the Nursing Manager, a lab representative and an HR representative. The record shows that the team members were provided with preset questions to ask applicants during interviews. After the applicant's interview, team members are asked to provide their input. Whether the input was in the form of feedback as to the qualifications of the candidate or a recommendation to hire the candidate is not explicit in the record. There was no evidence presented to show whether or not these recommendations were in writing; thus, there was no documentation of any such recommendation submitted into the record. Dr. Arthurs testified that the hiring was by consensus. However, he did not expound on how this was reached or what a consensus would consist of.

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[17] Ernie Segren, the lead at the Kennewick clinic, did not testify. However, Dr. Arthurs' testimony concerning Segren was the same as that of the other leads. Requests for leave with Segren's initials and Arthurs' signature were proffered into evidence. Dr. Arthurs speculated about what could happen before a lead would sign a leave slip. However, there is no concrete evidence on the circumstances surrounding the leave slips that contained Segren's initials and that were submitted into evidence.

Testimony by two of the doctors who were part of hiring teams, Drs. Schroff and Zolessi, reveals that no consensus was demanded or required of the team. The MDs testified that no rationale for final hirings was provided to the team members. In that regard, the team Schroff had been part of reached a consensus that 2 candidates be hired. Only one was ultimately hired and the team was not told why the other candidate was not similarly hired. The record shows that a year ago, the recommendation from a hiring team to hire was not followed. The number of hires resulting from teams' deliberations was not provided in the record.

c.) Evaluations

Some providers have been asked to "participate" in evaluating RNs and HCAs. When they do participate, they fill out an evaluation form left in their mailbox by the Nursing Manager with instructions to return it to the Nursing Department. The evaluation has 15 questions with "yes" or "no" boxes next to them for the provider to check whether the employee completed the duty or task and another series of boxes as to whether the completion was "poor," "fair," "good" or "excellent." Next to the check-off boxes is another box for the evaluator to elaborate on "what could be done to improve the process." The evaluation questions concern such areas of competency as completing tasks, follows directions, portrayal of the clinic to patients, relationships with others, and the like.

The record shows that although these evaluations are submitted by providers to the Nursing Department, they are used to help the evaluated employee improve their performance. An additional/separate evaluation is generated by the Nursing Department in conjunction with the Human Resources Department. That separate evaluation is used to determine the Nursing Department employees' pay. While the RN or RN lead evaluators will "consider" the providers' evaluation, no further evidence was presented as to what if any impact the providers' evaluations have on employees' pay.

While testimony shows that providers have occasionally been asked to rate CNAs on two or three questions, the actual evaluations that were submitted into evidence show providers have filled out the more comprehensive form that providers use for evaluating RNs and HCAs. Record evidence also shows a separate form for CNAs and some HCAs and another form for advanced HCAs and RNs. Regardless, when providers submit a completed evaluation form, they do not hear further on the evaluation.

Dr. Arthurs testified that he intends to use clinical leads to evaluate the providers, but his plan is "currently in the thought process." He states that in the past, the previous Medical Director completed any evaluation of a provider. The doctors who testified at the hearing in this matter asserted that they have not been evaluated since Dr. Arthurs assumed the Medical Director position.

d.) Discipline

The Clinical Director's testimony concerning MDs' alleged supervisory authority to discipline was discussed above, to a degree, in connection with their alleged responsibility to direct employees. Regarding "discipline leads," the record reveals that they may write an incident report but then so may other clinic employees. The record further reveals that leads may not authorize corrective action on their own as that

authorization rests with Dr. Arthurs. Although, leads may make recommendations for discipline, Dr. Arthurs testified that he "participates" in the investigation of any proposed discipline but he did not elaborate on the nature and extent of this participation. Dr. Arthurs also testified that no lead has been told that they have any disciplinary authority. Moreover, the leads who testified asserted that they do not have such authority.

Ernie Segren, lead at Kennewick, did not testify, but according to Dr. Arthurs, he disciplined an ARNP for an inappropriate comment made to a new employee. Dr. Arthurs states that he had a "personal discussion with Ernie about the situation, [and] he [Segren] volunteered that he would speak with the ARNP regarding the discipline and he not only did that, but he wrote a corrective action and participated in that corrective action." Dr. Arthurs did not describe his "personal discussion" with Segren or how Segren "participated" in the corrective action other than to say that he did not tell Segren what he should write. Besides the corrective action report, no other details were provided by the Employer. The corrective action report does not indicate any action visited upon the ARNP that affected the ARNP's terms and conditions of employment. There is no indication of any progressive discipline contained in the report or in the record, for that matter, and there is no evidence of a follow-up on the corrective action.

2.) RNs

The Employer has organizationally placed RNs, employed at the Pasco main building, under the Nursing Department. That Department is subdivided along lines parallel to that of the provider disciplines (i.e., family practice, OB/GYN, pediatrics, internal medicine). The Nursing Department consists of at least 20 certified nursing assistants (CNAs) or registered nursing assistants (RNAs),[18] 14 or more health care assistants (HCAs), and 8 of the petitioned-for RNs.[19]

The record is sparse as to the duties CNAs perform at the clinic. However, it appears from testimony that their certifications are geared more for working in a nursing home environment; i.e., performing duties more associated with that type of work. It appears from the record that the work performed by the CNAs in the clinic consists mostly of providing the initial "work up" of patients as they arrive for their appointments—performing weight checks, measurements, blood pressure checks, and the like. The record does not indicate CNAs' wage rates.

The record shows HCAs have more advanced skills than the CNAs and are trained more for doctor office visit environments than are CNAs. Although not to the level of an RN or LPN, HCAs are certified to perform such procedures as dressing diabetic patients' wounds, giving injections to patients, removing post-operative stitching, and performing pregnancy and urinalysis tests. The Nursing Manager assigns only one HCA to each provider, as mandated by Dr. Arthurs; however, there is one HCA per shift who is assigned "float" duty. In short, the float is responsible for making himself/herself

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[18] The difference between CNAs and RNAs is that CNAs are certified, while the RNAs, although registered, have not yet received their certification. I shall refer to both CNAs and RNAs as simply CNAs for convenience sake. Presently, the Employer does not employ any licensed practical nurses.

[19] The CNAs, HCAs and/or LPNs are not at issue in this case.

available to handle overflow when and where it arises in the clinic. HCAs earn between $19,700 and $23,800 a year.

The RNs in the Nursing Department perform standard RN functions such as administering IVs, immunizing clients through injections, drawing blood, etc. In addition to these regular RN duties, the clinic RNs also train CNAs in special procedures and administer tests for CNAs to certify them in these procedures, thereby enabling CNAs to advance to HCA status. The record does not indicate the amount of time it takes to complete this training and/or testing. The RNs earn $37,500 to $57,400 a year.

The Employer maintains that RNs are statutory supervisors in that they assign, responsibly direct, hire, evaluate, and/or discipline employees. The Employer further alleges that out of its group of eight RNs, there are three RN lead positions, of which only two of those positions are currently filled.

a.) Assign & Responsibly Direct

As with providers, the record indicates that RNs are "responsible" for the work of CNAs.[20] However, that responsibility emanates from their State licenses or certifications; as with the physicians discussed earlier, there is no record evidence that the Employer holds its RNs separately responsible for the work of CNAs or HCAs. The record contains only one discipline report for an RN and that discipline report dealt with tardiness. Additionally, the Employer did not submit evaluations completed by RN leads of RNs. Even so, the evaluation form does not rate RNs with regard to any responsibility to direct others.

Nursing Department Manager Mendez testified that RNs assess what is to be done and delegate those tasks (e.g., conducting pregnancy tests) to either HCAs or CNAs. However, the Employer did not detail in the record the nature and extent of the RNs' role in prioritizing and delegating such work to CNAs. Indeed, an RN testified that she receives her assigned tasks via oral requests from MDs, via patient charts which specify that certain tasks be performed generally in the order in which patients are received into the clinic, and/or via protocols which specify the nature and extent of the work to be performed by a nurse in caring for a particular type of patient. How the RN's testimony regarding the assignment of tasks relates, if at all, to Mendez' testimony regarding the assignment of tasks, was not explained by either party in the record.

The record also reveals that RNs also serve in a reportorial function for the Employer. For instance, testimony disclosed that, if an HCA or CNA "screws up," an RN will correct the screw-up and then reports the matter. However, the record does not detail the manner in which the RNs report such incidents and to whom the report is submitted.

The Nursing Manager makes the schedule for the RNs and the department administrative secretary makes the schedule for the HCAs. How these schedules are made appears to be contingent to some degree on how many providers will be present at the clinic. When the Nursing Manager was on vacation, the RN leads put together the

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[20] There is testimony that CNAs can affect RN licenses and HCAs can affect MD licenses. How they could "affect" the respective licenses is not clear in the record.

RN schedule. In this regard, a former RN lead testified that during her 18-month stint as a lead, for only 1 month did she schedule nurses. This former RN lead further testified that her scheduling work amounted to nothing more that scheduling full-time nurses to full-time shifts and per diem nurses as required. However, she also testified that she did not have the authority to schedule overtime, as that function was performed by the Nursing Manager, and that the schedules, which the former RN lead made up, were submitted to the Nursing Manager for revisions and/or approval. The record neither elaborates on why this former RN lead performed this scheduling function for only 1 month nor on the extent and nature of the review/revisions conducted by the Nursing Manager of the former RN lead's schedules.[21]

Any nurse can change the schedules if someone calls in sick. The nurse who receives the call will cross out the name of the employee not coming in and try to find a replacement if the administrative assistant is not available to make the calls. Significantly, the RNs do not have the authority to require anyone to come in. Moreover, the RN is to avoid calling in someone on overtime if possible. Other than that, it appears that the nurse goes down a list of those who are not at work at the time and who may be available to come in.

When a provider comes in unexpectedly, the RN on duty at the time attempts to call in the HCA normally assigned to that provider. However, during slow periods, if the provider's regular HCA would be on overtime if called in, and if someone else could be assigned who is already at the clinic, the person already present is assigned to the provider. Further, if there is a slow period and a provider is staying late at work and if the HCA assigned to that provider would be on overtime, that HCA is sent home by the RN or RN lead and someone else who is working is assigned to the provider.

An RN or RN lead may also change the schedule and send HCAs home when a provider leaves early. Thus, when such occurs, the HCA assigned to the provider is sent home. Those HCAs and CNAs not assigned to a provider during slow periods can be sent home. In addition to the foregoing Employer policies or procedures, the Employer further requires that during slow periods per diems be sent home first followed by those who would be accruing overtime.

If a nursing employee requests time off, a RN lead signs the request form to indicate that they have seen it and forwards the request on to the Nursing Manager who approves or disapproves of the request.

b.) <u>Hire or Effectively Recommend Hiring.</u>

Hiring for the Nursing Department is done through the Nursing Manager, Mendez. Mendez uses a panel that consists of the RN leads and her. The panel interviews candidates and according to Mendez, makes a decision on whom to hire. She maintains that any hiring must be by consensus of the panel. She explains that if

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[21] A dayshift RN, called by the Union to testify, asserted that she received her area (family, OB/GYN, pediatrics, internal medicine) of assignment on a daily basis from the preceding nightshift RN leads. However, this dayshift RN did not provide concrete evidence detailing how these assignments are made other than to assert that RNs were generally placed in the area of their choice, rather than the choice of the RN lead.

there were no consensus, the candidate would be reinterviewed. However, she admits that a situation has never arisen where there would be a need for reinterviews.

A former RN lead, Sophia Rubalcava, testified she was part of CNA hiring. In the hiring process, she would receive a set of pre-written questions to ask an applicant before an interview. She did not indicate who wrote the questions or who gave them to her. After the applicant's interview, she would make her recommendations about the applicant. However, contrary to Mendez, she testified that no consensus was sought, and there were times the panel did not agree amongst themselves. When that occurred, she asserted the Nursing Manager made the hiring decision. Rubalcava also testified that "at times" her recommendations were not followed; however, no number or percentage was proffered as to how often this occurred. In addition, she testified that the candidate with a majority vote would not always be the person hired. Indeed, Rubclava testified that she was not informed on how many CNAs were to be hired while she was part of the interview process.

c.) Evaluations

RNs fill out evaluation forms for HCAs and CNAs while RN leads will, in addition, fill out evaluations for RNs. However, the Employer did not submit into the record a RN evaluation completed by a RN lead. Regardless, the evaluation forms completed by RNs appear to be identical to the evaluation forms completed by providers (MDs and mid-levels). Three questions on the RN evaluation form are reserved for RN leads to complete. One of the questions relates to attendance at meetings, a second relates to punctuality, and the third relates to keeping licenses (e.g., CPR) current. The RN lead's evaluation of an employee appears also to require some involvement of the Nursing Manager, yet, the extent and nature of that involvement is not clear in the record.

After an RN completes an evaluation form, it is submitted to the Employer's Human Resources Department, which, by use of a computer program, assigns numerical scores and weights to the evaluated categories in terms of percentages. The scoring and weighed percentages will factor into the amount of a raise that the evaluated employee may receive. However, once the RN completes the evaluation and it is submitted to HR, the RNs play no further role in the scoring/weighing/percentage process. Beyond completing the evaluation forms, the RNs also play no role in determining the actual percentage range of pay increase that an evaluated employee may eventually receive. For instance, last year, raises ranged between one and five percent and this year the top of the range was three percent. Record testimony establishes that RNs are not involved in the decision-making loop as it relates to the Employer's setting of the annual range of pay increase available to evaluated employees. Indeed, RNs do not receive prior notice regarding the amount of pay increases settled on by the Employer.

After the computer program is applied to an evaluation completed by an RN, a computer will generate or produce a pre-established written evaluation correlated to the scores for each area evaluated. The final evaluation categories are not the same as those filled out by the RNs. The final evaluation scores such performance competencies as attendance and punctuality, cooperation, customer service, dependability, quantity and quality of work, and other categories.

d.) Discipline

No employee handbook or Employer policy regarding discipline was submitted into evidence.[22] However, record testimony indicates that the Employer has implemented a progressive disciplinary procedure for tardiness in its Nursing Department at the Pasco main building.[23] While not part of that procedure, employees may receive one or more informal "verbal" warnings, which are orally presented to employees and memorialized in the form of a written "communication." An RN lead testified that a RN lead and the Nursing Manager, Mendez, sign the informal "verbal" communications issued to employees.

Aside from the informal warnings, which have no impact on wages or job status, the progressive disciplinary procedure is initiated by the issuance of a formal "verbal" warning, which is also memorialized in writing. RN leads do not possess the authority to issue a formal verbal warning without, at the very least, obtaining Mendez's approval and signature.[24] Following the formal "verbal" warning is a formal written warning. After a formal written warning is issued, the procedure appears to require probation, followed by suspension, with the next and last step being discharge. The Nursing Manager stated that all issued discipline in the Nursing Department concerned tardiness or gossiping. However, the Employer submitted no documentation (e.g., disciplinary procedure, rules, actual discipline, etc.) relating to discipline for gossiping.

In the case of tardiness, the Employer submitted forms revealing that once a formal "verbal" warning is issued to an employee, a check-up is performed after 30 days on that employee by one of the lead RNs who runs a computer sheet of the employee's punch-in times. If the employee has not improved, the Employer mandates that the employee be issued a written formal warning with another check-up 30 days later. If the tardiness continues, Mendez places the person on probation. When a suspension or dismissal is contemplated, the Human Resources Department will conduct a review of the employee's record to insure that all steps in the disciplinary procedure were properly followed, including the 30 and 60-day check-up schedules indicated on the disciplinary forms.

Mendez testified that, at some point earlier this year and because of attendance problems, she instructed RN leads to more closely monitor attendance in stricter compliance with the Employer's tardiness "policy." In particular, Mendez essentially informed the leads, that if employees were a minute tardy here or there and if there was no conflict with patient care, the leads need not report such tardiness. However,

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[22] When the Nursing Manager was questioned as to whether there was any job description authorizing nursing leads to unilaterally impose discipline, she responded, "The job description is what their job and duties and responsibilities are, so much as a policy to tell them they can unilaterally do that, I can't think of one."

[23] The Employer provided no evidence regarding what, if any, progressive discipline procedure it applies in other aspects of its operations beyond the Nursing Department at the main facility at Pasco.

[24] With the one exception noted below concerning Mendez's leave from work, RN leads do not possess authority to issue any formal discipline without Mendez's approval.

Mendez instructed Leads to report to her if employees were late two minutes on a daily basis because such tardiness would probably have an adverse impact on patient care. [25]

Notwithstanding Mendez' testimony that she is requiring the RN leads to strictly monitor and report tardiness problems to her, one lead, Oralia Garcia, testified that in determining tardiness, she came up with a 5-minute grace period but she also states that no one told her what the procedure is in this regard.[26] Consequently, Garcia has been using 5 minutes as a standard that she had previously used somewhere else that was not specified in the record. As far as this RN lead was concerned, the 5-minute grace period has not been a problem, as the Employer has not disciplined her for using this standard. However, there is no evidence in the record establishing whether, prior to the hearing in this case, Employer management/supervision was even aware that Garcia was utilizing a grace period that directly conflicts Mendez's explicit policy as laid out above.

While Mendez testified that RN leads have the authority to issue verbal and written warnings, the record makes clear that the RN leads may not issue any form of discipline without coming to Mendez and having her sign off on all warnings. Mendez further testified that the only time leads have not come to her before issuing any formal discipline was when she was on vacation, in December of last year, when she delegated, in writing, her authority to the leads for the period of her vacation. With the exception of this December vacation period, the leads have always come to her for "consultation" on discipline. However, the Employer did not elaborate on the nature and extent of these "consultations." Regardless, one of the RN leads testified that she would check an employee's attendance record to see if there is a tardiness problem with an employee. If it appears the employee is late "once in a blue moon," she will issue the employee an informal written communication as a "friendly reminder." But if an employee has many such communications in his or her file, the lead will bring that to Mendez's attention, presumably in accord with the guidelines and instructions Mendez issued the leads.

Moreover, two RN leads testified that Mendez tells them what discipline to issue to an employee with regard to tardiness. However, the record is silent as to whether the leads merely report tardiness situations to Nursing Manager Mendez' and whether the leads make any form of recommendation in this regard. The record also does not elaborate on whether formal discipline regularly ensues when the RN leads bring a tardiness situation to Mendez and whether she, or anyone else for that matter, conducts an independent investigation or contacts the tardy employee prior to issuing formal discipline. Indeed, the record indicates that the only probation/suspension issued by a lead without Mendez's approval was in December when Mendez was on vacation and had delegated her authority to the leads. Moreover, RN leads testified that, after initial

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[25] The Employer, in its brief, asserts that the RNs have the authority to change policy, citing the Nursing Manager's testimony. However, the Nursing Manager, after being asked directly whether she knew of a "single occasion" where any of the Employer's nurses "has taken it upon themselves to draft a policy by themselves and provide it to you…" She responded, "I can't think of any particular time that that did happen…"

[26] Garcia has been employed by the Employer as an RN for about a year and within that year, she became RN lead. However, the record does not pinpoint the date when Garcia was elevated to a lead.

formal discipline issues, there is no discretion whether or not to follow up during the times required.

Additionally, the record reveals that only Mendez has the authority to place a Nursing Department employee on probation and only the Human Resources Department has the authority to levy a suspension or dismissal. According to Mendez, if a suspension or dismissal is contemplated with regard to tardiness, she or the leads could be disciplined if the check-ups were not properly followed.[27]

D.) <u>The Employer's Support Services Operation</u>

As noted above, the medical clinic and support services are located in the same Pasco building. However, the reporting structure for support services is different from that of the medical clinic. Support services itself is divided into social services and facilities. The social services side is further divided into four "teams:" First Steps; Women, Infants & Children (WIC); Outreach; and Managed Care. The professionals at issue here are located in First Steps and WIC. Three BHSs and four RNs are in First Steps. Also located in First Steps are four infant case managers/community health workers and four Outreach community health workers. There is one RD (registered dietician) located in WIC, although she performs duties in both WIC and First Steps.

First Steps is specially designed for maternity support. In that regard, RNs are required not only to have a B.A. in nursing, but they are also required to have at least 2 years experience working in a community setting, such as in a health department or in community education. First Step operates like a visiting nurses service where the RNs spend 99% of their time seeing clients in the clients' homes and only 1% of their time in office visits, although the choice of home or office visit is the clients'. The nurses counsel pregnant women on the different medical needs they might require during the different trimesters of their pregnancy. Although the RNs do not perform any medical procedures in the field, they do perform RN functions by devising plans of action for particular clients and referring clients to MDs for tests. The RNs also refer clients to a BHS if they have emotional problems associated with their pregnancies and send for community health workers for such needs as transportation; e.g., if a client needs food, a community health worker would drive the client to a food bank. The RNs are required to be licensed RNs. They earn between $42,700 and $46,900 a year.

As mentioned above, BHSs see clients for emotional problems arising around clients' pregnancies. BHSs also see clients in the clients' homes to perform physio-social assessments and will send for a nurse if a client is too sick for assessment. BHSs apparently earn between $15 and $20 an hour.

The RD makes nutritional evaluations and deals with maternity clients in her office on their nutritional, weight, nausea, and vomiting problems. The record reveals

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[27] Mendez did not elaborate on the basis for her testimony that RN leads could be disciplined for failing or refusing to follow the Employer's detailed check-up procedures and the Employer submitted no evidence showing that RN leads had, indeed, been disciplined for such a failure/refusal. Indeed, no documents supporting such accountability were submitted into the record.

that the pay for "dietician" ranges from $16,800 to $39,100 a year. The record did not reveal the current RD's pay.

Doctors Schroff and Zolessi, from the Pasco medical clinic, refer about 500 clients to social services and have contact with Support Services every day. According to the Social Services lead (a nonprofessional), "We work a lot with Dr. Schroff and Dr. Zolessi and they refer clients to us for different things that the client might need. So it is a day-to-day activity with them. We do work with them closely."

Connie Rode, one of the RNs in Support Services, also interacts with medical clinic personnel. This occurs when she is called over to the medical side by OB/GYN to teach its patients about diabetes and glucometers. She also helps out at the medical clinic as a medical clinic nurse when needed. On one occasion, she worked 40 hours during a week on overtime at the medical clinic. While Rode admitted that such overtime was "very unusual," she also testified that she is at the medical clinic every week.

Both Rode and Joanna Navarro, another RN in First Steps, had transferred from the medical clinic side of the Employer to First Steps. Other than this testimony, there was no other evidence submitted on transfers, temporary or otherwise. There is no evidence on any shared benefits with clinic professionals. The Employer has only one HR Department listed in its organizational chart, which is separately supervised from either the medical clinics or Social Services. While it appears from the record that the Employer's HR Department centrally controls labor relations in the Employer's medical clinics, the parties did not elaborate upon this point in the record as it relates to other aspects of the Employer's Social Services operations at the Pasco facility at issue in this proceeding.

As for any hiring involvement of the First Step nurses, Connie Rode, an RN in First Steps, was on a hiring team for only one interview. The interview was for an applicant for a BHS position. Rode states that she was one of 5 people on the team. She was given questions to ask, but she was not asked for her recommendation. Further, she was not part of the interview process for the rest of the candidates. Moreover, the candidate she had interviewed was not selected. She was not told why she was not part of the rest of the interview process.

The record reveals that Rode also has occasion to request that a community health worker transport clients who have no car, or request that a community health worker drive a client to a food shelter. The record and the arguments of the parties provide no details regarding whether the RNs in Social Services possess indicia of supervisory authority. Indeed, it appears that the Employer's position with regard to the RNs in Social Services is that they should be excluded from the Unit based on a lack of community of interest.

II.) POSITIONS OF THE PARTIES

The Petitioner has petitioned for a Unit of professional employees located in two separate buildings. The Employer essentially raises three contentions. First, the Employer contends that the Unit is inappropriate because there is nothing to distinguish inclusion of the professional employees in social services from those professional employees whom neither party seeks to include in the Unit. Second, the Employer

contends that its MDs, RNs and their respective leads, and the Kennewick medical clinic lead are statutory supervisors because they assign, responsibly direct, hire or effectively recommend hiring, evaluate, and/or discipline employees. Third, the Employer contends that its MDs are managerial employees because they effectively recommend protocols for adoption by the Employer.

III.) ANALYSIS

A.) Unit Appropriateness (Social Services)

The petitioned-for Unit consists of all professional employees at the Employer's Pasco and Kennewick facilities. I specifically note that the Employer contends *only* that the petitioned-for employees lack a sufficient community of interest to be included in a single bargaining unit. The Employer does not contend that the Unit is inappropriate because it *excludes* other employees that Employer would *include*. Rather, the Employer contends that the *only* appropriate unit is one limited to the professionals on the "clinical, medical side of the house" and that *inclusion* of the social services professionals creates an arbitrary, heterogeneous, or artificial grouping of employees.

In determining whether a multi-facility unit is appropriate, the Board evaluates the following factors: employees' skills and duties, terms and conditions of employment; employee interchange; functional integration; geographic proximity; centralized control of management and supervision; and bargaining history. *Stormont-Vail Healthcare, Inc.*, 340 NLRB No. 143, slip op. at 3) (Nov. 28, 2003); *NLRB v. Carson Cable TV*, 795 F.2d 879, 884 (9th Cir. 1986).

Here, all the employees petitioned-for are stipulated to as professional employees. Further, the RNs in both the medical clinic and in social services possess the same license and nursing degree. Although some skills possessed by RNs in social services are not possessed by RNs in the medical clinics, all the RNs have the same basic training in nursing. Indeed, social services RNs, although they do not provide primary care, use their knowledge and skills as a nurse to inform clients of the treatment and symptoms related to pregnancy. Social Services RNs are also experienced in recognizing symptoms of certain illnesses where a referral to a specific MD specialist would be in order. While it is true that the RN skills in social services may be different from those possessed by RNs in the medical clinics, the difference is no more material than the skills difference that exist for MDs in their respective areas of practice, i.e., OB/GYN, internal medicine, family care, or pediatrics.

Social services RNs' pay range is within that of the clinical nurses' pay range.

There is also employee contact and interchange between social services and the medical clinic. Two doctors at the Pasco medical clinic regularly refer patients to social services and RNs in social services have referred clients to the medical clinic. Also, two of the 4 social services RNs transferred from the Pasco medical clinic. Additionally, both social services and the Pasco medical clinic are located in the same building. The record further reveals that Unit employees working in social services work with each other to provide integrated Employer services to pregnant women.

I also note there is no evidence of any prior bargaining history with regard to the Unit.

Based on the above, and the record as a whole, I conclude that the social services professionals share a sufficient community of interest with the other petitioned for professionals to warrant their inclusion in the Unit.

B.) Supervisory Issue

Section 2(3) of the Act excludes "any individual employed as a supervisor from the definition of 'employee.'" Section 2(11) of the Act defines "supervisor" as:

> any individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not of a merely routine or clerical nature, but requires the use of independent judgment.

Section 2(11) is to be read in the disjunctive, and the "possession of any one of the authorities listed in [that section] places the employee invested with this authority in the supervisory class." *Ohio Power Co. v. NLRB*, 176 F.2d 385 (6th Cir. 1949), cert. denied 338 U.S. 899 (1949). The exercise of that authority, however, must involve the use of independent judgment. *NLRB v. Kentucky River Community Care Inc*., 121 S.Ct. 1861 (2001). The legislative history of Sec. 2(11) indicates that Congress intended to distinguish between employees who may give minor orders and oversee the work of others, but who are not necessarily perceived as part of management, from those supervisors truly vested with genuine management prerogatives. *George C. Foss Co.*, 270 NLRB 232, 234 (1984). For this reason, the Board takes care not to construe supervisory status too broadly because the employee who is deemed a supervisor loses the protection of the Act. *St. Francis Medical Center-West*, 323 NLRB 1046 (1997). Thus, the burden of proving supervisory status is on the party alleging that such status exists. *Kentucky River*, supra. That means that any lack of evidence in the record is construed against the party asserting supervisory status. *Freeman Decorating Co.,* 330 NLRB 1143 (2000). Moreover, whenever evidence is in conflict or otherwise inconclusive on particular indicia of supervisory authority, the Board will find that supervisory status has not been established. *Phelps Medical Center*, 295 NLRB 486, 490-91 (1989). Additionally, mere opinions or conclusory statements do not demonstrate supervisory status. *St. Alphonsus Hospital*, 261 NLRB 620 (1982), enfd. 112 LRRM 3168 (9th Cir. 1983); *Chevron U.S.A.*, 309 NLRB 59 (1991).

The Board has recognized the tension between the "professional judgment" that is required of a professional employee covered by the Act pursuant to Section 2(12) and the "independent judgment" that excludes an employee from coverage by virtue of Section 2(11). Prior to *Kentucky River*, the Board endeavored to resolve this tension in cases involving the supervisory status of professional employees by holding that the use of professional judgment to direct employees was not "independent judgment." However, in *Kentucky River*, the Supreme Court held that the Board should not exclude from the "independent judgment" required in Section 2(11) professional or technical judgment when used in directing less-skilled employees to deliver services. The Court reasoned that such a per se approach was inconsistent with the language of Section 2(11) and its previous decision in *NLRB v. Health Care and Retirement Corp.*, 511 U.S. 571 (1994), in which it had ruled that the statute applies no differently to professionals than to other employees.

Although the *Kentucky River* Court found the Board's interpretation of "independent judgment" to be inconsistent with the Act, the Court recognized that it is within the Board's discretion to determine what scope or degree of discretion meets the statutory requirement that a supervisor use independent judgment. Id. at 1867. The Court stated: "Many nominally supervisory functions may be performed without the 'exercis[e of] such a degree of … judgment or discretion … as would warrant a finding' of supervisory status under the Act." Id., citing *Weyerhaeuser Timber Co.*, 85 NLRB 1170, 1173 (1949). The Court also agreed with the Board that if the Employer limits the degree of independent judgment by, for example, detailed orders, the individual may not be appropriately held a supervisor. *Kentucky River*, above at 1867, citing *Chevron Shipping Co.*, 317 NLRB 379, 381 (1995). Additionally, while the Court explicitly refrained from interpreting the phrase "responsibly to direct," the Court suggested that the Board could interpret this phrase by "distinguishing between employees who direct the manner of others' performance of discrete tasks from employees who direct other employees as [Section] 2(11) requires." *Kentucky River*, above at 1871 (citing *Providence Hospital*, 320 NLRB 717, 729 (1996).

The Employer contends its MDs and RNs (including the MD, RN and Kennewick leads) are statutory supervisors. Regarding MDs and MD leads, the Employer contends they are 2(11) supervisors because they assign, responsibly direct, hire, and/or evaluate. The Employer alleges that the MDs leads should be also excluded from the Unit on the basis of their managerial status.

1.) Physicians (MDs)

a.) Assign & Responsibly Direct

In the instant case, the Employer contends that the MDs' assignments and responsible direction of RNs and HCAs support a finding that MDs possess indicia of supervisory authority. In this regard, the record shows that the HCAs perform much of their work, including some of their most significant functions, on their own and outside the immediate presence of the MDs or the midlevels. In particular, the HCAs work independently to receive patients from the waiting room and process them for treatment or examination, perform standard tests on patients at the outset and in preparation for their physical examinations by a provider (MD or midlevel) and accomplish other administrative duties. Notwithstanding this independence, the Employer argues that the MDs use independent judgment to assign and/or to responsibly direct RNs and HCAs. This argument focuses primarily on the assignments or directions given by MDs to the nursing staff during patient examinations such as having HCAs or RNs set up the proper equipment for use in an examination, having the RNs or HCAs insure that X-rays or other tests are performed on patients, and/or having the RNs or HCAs perform such procedures as removal of post-operative stitches, wound treatment, injections, IVs, monitoring, and other regular patient examination procedures such as obtaining additional vital signs, blood pressure, weight and pulse readings.[28] While the record reveals that a number of these discrete tasks are routinely performed by the HCA assigned to work with the provider, the record further reveals that at least a portion of the

[28] Once more, I note that midlevels, as well as the MDs, assign discrete tasks to HCAs and/or to nurses. However, the Employer does not seek to exclude midlevels from the Unit.

providers' orders for the performance of such discrete tasks are submitted by the providers to a nurse's station, which in turn, distributes the performance of those orders, which can be completed by a nurse, to other nurses in the order in which the orders come to the station.[29] In these circumstances, the record raises the issue of whether the MDs use independent judgment with the regard to assigning work to nurses and/or with regard to responsibly directing nurses in their work.

Since Section 2(11) explicitly requires a statutory supervisor to use independent judgment in assigning and responsibly directing employees, determining whether an alleged supervisor's assignment or direction renders that person a statutory supervisor requires deciding whether the assignments or directions given require independent judgment or whether such are merely routine. *Providence Hospital*, 320 NLRB at 729. In this case, the record reveals that the preparation of patients for the MD and the orders the MD directs to the nursing staff are those procedures and duties HCAs and RNS are trained to perform and routinely perform everyday. After *Kentucky River*, the Board has continued to construe as "routine" the direction of tasks that are repetitive and with which the directed employees are adequately familiar. See *Franklin Home Health Agency*, 337 NLRB 826 (2002). In *Northern Montana Health Care*, 324 NLRB 752 (1997), the Board found that LPNs did not use independent judgment since they only directed nurses aides in routine tasks of patient care that recurred daily, such as taking residents' vital signs, and assisting them to the dining room and on short walks. Likewise, in *Evangeline of Natchitoches, Inc.*, 323 NLRB 223 (1997), the Board held that LPNs' direction of nurses aides was routine or technical and did not require independent judgment because of the nature of the tasks and the aides' familiarity with their patients. Furthermore, proof of independent judgment in the assignment or direction of employees entails the submission of concrete evidence showing how such decisions are made. *Harborside Healthcare, Inc.*, 330 NLRB 1334, 1336 (2000); *Crittenton Hospital*, 328 NLRB 879 (1999); *Franklin Home Health Agency*, above.

Here, the MD, as a professional employee, no doubt uses his or her well-developed expertise and professional judgment in making a diagnosis and settling on a course of treatment or care for a patient. However, the exercise of such professional judgment, alone, does not establish the existence of supervisory authority. See *Ten Broeck Commons*, 320 NLRB at 811 ("There is an important distinction between designing complex work tasks and directing employees in carrying out those tasks.") In short, the instant record reveals that the MDs effectively order that certain, discrete tasks be performed but the record does not disclose concrete evidence as to how the assignment or direction of those tasks are carried out. For instance, the record does not elaborate on who actually assigns or responsibly directs such work and who is involved in that assignment decision. Moreover, what personnel options, if any, does the assigner have when deciding whom among the available nursing staff should perform the work and what factors are considered when making such decisions? What the record does reveal is that the Nursing Department or the Nursing Manager has significant supervisory oversight over the nurses but the full extent and nature of that

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[29] Again, the nurses do not perform certain ordered tasks, such as X-rays. I would assume other tasks, such as certain lab tests, are also not performed by the nurses. It further appears from the record that the nurses or the nurse's station might very well relay these tasks or MD orders onto non-nursing personnel who are responsible for insuring the performance of such tasks.

oversight is not detailed in the record. As noted above, providers submit orders for the performance of discrete tasks to a nurse's station, which in turn, distributes those orders in the order in which they are received. Thus, it appears that MDs merely pass their medical orders on to a nursing system that has its own established manner for assigning work and that manner also appears to be rather routine in most cases.

The record further reveals the Nursing Department or Manager, and not the MDs, actually schedule and assign the nursing staff to their work locations and shifts.[30] Yet, the record fails to elaborate on the Nursing Department or Manager's oversight of the nurses work throughout the course of the day and in particular with regard to the assignment and/or direction of the nursing staff in the performance of their assigned tasks. While the record reveals that each MD or mid-level is assigned a particular nurse by the Employer, it does not reveal what occurs when an MD or mid-level orders a medical procedure that is beyond the education, training and/or licensing/certification of the nurse assigned to that MD or mid-level; i.e., who is actually responsible for assigning and responsibly directing such tasks; what tasks are solely within the province of RNs, HCAs, CNAs, and/or solely within the province of the nurse assigned to the provider -- in short, whom does the Employer hold accountable for such assignments or directions? Also, what procedures are the RNs, HCAs, and CNAs equally capable of performing? The Employer did not detail concrete evidence of this nature in the record.

With respect to the Employer's protocols, the record does not elaborate on how and when the "protocols" come into play and whether such dictate the medical care/procedures to be ordered by the MDs, the class of nurse (RNs, HCAs, CNAs) which is to perform that care/procedure, and/or the care/procedures to be performed by the nurses. Notwithstanding the lack of evidence in this regard, it does appear that the Employer requires its medical personnel to follow such protocols, where applicable. Yet, the Board has held that activities such as checking off items on a preprinted list of standard tasks, orienting aides to patients and to a patient's plan of care, does not demonstrate the degree of independent judgment necessary to establish statutory supervisory authority. See *Franklin Home Health Agency*, above and *Kentucky River*, 121 S. Ct. at 1867.[31]

The Employer relies heavily on *Schnurmacher Nursing Home v. NLRB*, 214 F.3d 260 (2nd Cir. 2000) where that Court held that "[in] determining whether 'direction' in any particular case is responsible, the focus is on whether the alleged supervisor is held fully accountable and responsible for the performance and work product of the employees he directs." However, the facts in *Schnurmacher* are distinguishable from those here. In *Schnurmacher*, an RN was disciplined by her employer for "unacceptable performance"

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[30] I note that the Union, in questioning one of their witness (a day-shift RN), elicited testimony that the RN finds out from the night-shift lead RNs what area of care they will be working in during the shift following the night. However, that same testimony established that the area of assignment is not based on independent judgment by the nightshift RN lead; rather, it is based on the desire of the dayshift RN lead to work in his or her preferred area of practice. Thus, this testimony only serves to further confuse what is already a relatively unclear picture of the assignment and direction of work in the Employer's clinics.

[31] Moreover, assuming the MDs assign discrete tasks to the nursing staff based on an assessment of employees' skills, where the matching of skills to requirements is a routine function, such does not reflect supervisory authority. *Ten Broeck Commons*, 320 NLRB 806 (1996); *Esco Corp.*, 298 NLRB 837, 839 (1990).

in connection with her failure to properly assess that a patient needed oxygen and to ensure that her staff administered the oxygen to the patient. Here, there is no evidence that the Employer likewise holds the physicians so accountable. Indeed, the Employer did not submit into the record any evidence showing that MDs are evaluated and/or disciplined with respect to their alleged authority to assign and/or responsibly direct employees in their work. It is true that testimony indicated the MDs are accountable for the results of care provided to their patients, but that accountability was identified as a requirement of the State of Washington; not a requirement of the Employer. The Board has found that a government requirement that nursing staff be supervised by a supervising physician does not establish that the Employer's physicians meet 2(11) supervisory requirements. See *Third Coast Emergency Physicians, P.A.*, 330 NLRB 756 fn1 (2000).

Moreover, even if the Employer holds the MDs responsible for the treatment of their patients, it is this treatment for which they are held responsible and not the direction or actions of the nursing staff, who fall under the management/supervision of the Nursing Department and its Manager, Mendez. Further, the Nursing Department assigns those employees to assist the MDs, which warrants the conclusion that the MDs play no role in such assignments. The Court in *Kentucky River* suggested a distinction be drawn between employees who direct the manner of others' performance of discrete tasks from supervisory individuals who direct other employees. That distinction is evident here as the MDs, at most, direct the manner of performance of discrete tasks to be performed by the RNs or HCAs and then, in only rare instances.

The Employer also contends that the "clinical [MD] leads" are statutory supervisors because they approve providers' requests for time off. However, as the evidence shows, the leads merely sign the requests to indicate they have seen them and that the Clinical Director independently reviews the schedule for the requested time and retains the authority to make the final decision on granting time off when conflicts in scheduling occurs.

The Employer contends that lead Mayuga is a statutory supervisor because she creates the clinical providers' night call list. However, as noted earlier, the record does not detail the nature and extent of "input" that is given by the providers to Mayuga. Moreover, there is nothing in the record that describes how she puts this list together. Thus, there is no concrete evidence that creating the call list requires the use of independent judgment. See *Harborside Healthcare*, above (charge nurses' call-in authority was not supervisory in the absence of evidence disclosing how they decided which employees to call). Indeed, there is testimony that indicates Mayuga performs this service as part of the requirements mandated by hospitals where the MDs maintain privileges. In light of the above and the record as a whole, insufficient evidence exists to establish that Mayuga possesses indicia of supervisory authority with respect to her role in the providers' night call list.

In view of the above and the record as a whole, I find that the Employer has failed to meet its burden of establishing that the MDs and/or the MD leads possess the authority to assign and/or to responsibly direct employees in the interest of the Employer.

b.) Hiring

The Employer contends that the MDs have authority to hire in that the Medical Director, Dr. Arthurs, testified that MDs participate on hiring committees, which are required to reach consensus. However, the testimony of the only MD witness who served on one of these committees clearly shows no consensus was either required or reached. Further, the evidence points out that the recommendations of the committees have not always been followed. Indeed, there is no evidence as to what role the committees' recommendations play in any final decision. Absent detailed, specific evidence of supervisory authority, mere inferences or conclusionary statements without supporting evidence are insufficient to establish supervisory status. *Quadrex Environmental Co.*, 308 NLRB 101 (1992). In sum, I cannot on this record conclude there is any causal connection between hiring and a hiring committee's recommendation.

c.) Evaluations

The record shows that providers complete evaluations given to them by the Nursing Manager. However, the purpose of those evaluations is to provide the evaluated employee with a means of improving his or her performance. Contrary to the Employer's contention, Section 2(11) does not include the authority to "evaluate" in its enumeration of supervisory functions. Thus, when an evaluation does not, by itself, affect the wages and/or job status of the employee being evaluated, the individual performing such an evaluation will not be found to be performing a statutory supervisory function. See *Harborside Healthcare*, above, *Elmhurst Extended Care Facilities*, 329 NLRB 535 (1999); *Williamette Industries, Inc.*, 336 NLRB 743 (2001). Here, the Nursing Manager testified that the evaluations could be "considered" in the employees' final evaluation. Yet, the Employer did not elaborate on what "considered" means as it ultimately relates to employees' wages or job status.

As for Dr. Arthur's future plans to have discipline leads complete evaluations, a determination of proper unit placement must be based on what an individual filling the classification actually does now, as opposed to what he or she speculatively may be doing some time in the future. See *Southwestern Bell Telephone*, 222 NLRB 407 (1976).

In light of the above and the record as a whole, I find that the MDs do not possess any of the indicia of supervisory authority in connection with their role in employee evaluations.

d.) Discipline

With one possible exception, there is no evidence that a provider or lead issued discipline that affected any employees' terms and conditions of employment and there is no evidence the MDs or leads were informed of any supervisory authority to discipline. Indeed, those who testified denied possessing any authority to discipline. The one possible exception concerns the disciplinary form that Segren, the Kennewick lead had apparently written and signed. However, before that disciplinary form was issued, the Clinical Director brought the incident underlying the discipline to Segren's attention and "discussed" the situation with Segren. Neither the contents of this "discussion" nor the reasons that resulted in the write-up are disclosed in the record. Thus, there is no

evidence to establish that Segren possessed or exercised any independent judgment in connection with this disciplinary incident. Moreover, there is no evidence that the employee's terms and conditions of employment were affected by any action of Segren. Under these circumstances and in light of the record as a whole, I cannot find that Segren's conduct in this regard evidences the possession of authority to discipline or to effectively recommend the same. See *Vector Hospital-Los Angeles*, 328 NLRB 1136 (1999).

The Employer further argues that the Kennewick lead is the highest-ranking person at the site. However, being the highest-ranking employee is secondary indicia. See *Training School at Vineland*, 332 NLRB 1412 (2000). Without the presence of primary indicia of supervisory authority, the Board will not find an employee to be a statutory supervisor. Id.[32]

In light of the above and record as a whole, I find that the Employer has failed to meet its burden establishing that the MDs, the MD leads, and/or that the Kennewick lead possess indicia of supervisory authority as that term is defined in Section 2(11) of the Act.

e.) Managerial Status

The Employer's contention that MDs are managerial employees is solely based on the MD role to "develop" protocols and "recommend" their adoption to Dr. Arthurs. The Employer also asserts that all of Dr. Zolessi's committee recommendations for protocols have been adopted. The Employer does not elaborate on whether all other committees' recommendations have been adopted.

However, the record shows that MDs do not establish or "recommend" policy. Rather, the Clinical Director, in discussing the discipline committees and their role in policy, described a discipline committee's recommendation as vital solely with regard to input into how "the *clinical piece* of that policy is to be carried out." Even if a committee's recommendations for protocols are always adopted, this does not show the committee members formulate and effectuate management policies, only that they have limited input into the "clinical piece" to which their practice of medicine is generally confined. The Board has long defined managerial employees as those who formulate and effectuate management policies by expressing and making operative the decisions of their employer, and those who have discretion in the performance of their jobs independent of their employer's established policy. See *NLRB v. Yeshiva University*, 444 U.S. 672 (1980); *General Dynamics Corporation*, 213 NLRB 851 (1974). The Board has also held that

> [w]ork which is based on professional competence necessarily involves a consistent exercise of discretion and judgment, else professionalism would not be involved. Nevertheless, professional employees plainly are not the same as management employees either by definition or in authority, and managerial authority is not vested in professional employees merely by virtue of their professional status or because work

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[32] The Employer also mentions that nurse leads receive $1.00 an hour more. However, again, this is a secondary indicium.

> performed in that status may have a bearing on company discretion. Likewise, technical expertise in administrative function, which may involve the exercise of judgment and discretion, does not confer executive-type status upon the performer. A lawyer or certified public accountant working for, or retained by a company may well cause a change in company direction, or even policy based on his professional advice alone, which, by itself would not make him managerial. *General Dynamics Corporation* at 857 - 858.

Here, the MDs' role on the committee is limited to the "clinical piece" of their respective areas of practice. The record does not elaborate on what occurs if and when the "clinical piece" impacts other aspects of the Employer's operations or policies. For instance, the record does not elaborate whether the committee may adopt a "clinical piece" which has a significant impact on the Employer's financial budget or deviates from its policies or direction of its operations. The record also does not reveal Dr. Arthurs' role in the process and whether he conducts an independent investigation of such matters when the impact is significant. In short, the record provides only a narrow view into the impact of the committees' role on the Employer's "clinical piece" rather than a broader view of the relevant and material impact of such protocols on the policies and direction of the Employer's operations. On the basis of the foregoing and the record as a whole, I find that the Employer has failed to meet its burden of establishing that the MDs should be excluded from the Unit due to their alleged managerial status.

2.) Registered Nurses

The Employer makes much of the RNs' position descriptions in supporting its case that RNs are statutory supervisors. However, without listing all those provisions in the position descriptions relied on by the Employer, the analysis must first start with the acknowledgement that the issuance of "paper authority" which is not exercised does not establish supervisory status. *East Village Nursing & Rehabilitation Center v*. NLRB, 165 F.3d 960 (D.C. Cir. 1999). Based on the following and the record as a whole, I find that the Employer has failed to meet its burden of establishing that RNs possess any of the indicia of supervisory authority as that term is defined in Section 2(11) of the Act. See *Control Services*, 314 NLRB 421 (1994).

a.) Assign & Responsibly Direct

The Employer argues that RNs and RN Leads, like the MDs, are responsible for the work of others. As with the MDs, however, there is no evidence that the Employer holds RNs accountable for the tasks they delegate to others. In particular, no evidence was submitted that any RN was disciplined in connection with his or her alleged responsibility for the actions of others, and the RN evaluation form similarly does not evaluate any purported responsibility to direct employees. Thus, the facts here are distinguishable from those found in *Schnurmacher*, where the Court found that purported supervisors were held accountable by their employer for responsibly directing employees. See, also *Franklin Home Health*, supra where there was no evidence that a nurse was held responsible for assessing whether a patient required immediate medical attention and for delegating the performance of the medical attention to other employees. Also found relevant was that the RN's performance appraisals did not rate RNs with respect to their supervisory ability.

With regard to the RNs' assignments to HCAs and CNAs, the Employer fails to show that such assignments are anything more than the assignment of discrete tasks to be performed by an aide who is adequately trained in performing the assigned work. Moreover, generally showing other employees the correct manner in which to perform a task does not confer supervisory status. See, e.g., *Franklin Home Health*, above. Thus, that the RNs may teach CNAs the skills to become HCA does not establish 2(11) supervisory status. See also *S.D.I. Operating Partners*, 321 NLRB 111 (1996); and *Ohio River*, 308 NLRB 686, 716 (1991).

The Employer also argues that the RNs or their leads may reassign the floater HCA whose primary function is to float around and provide assistance to those areas requiring assistance. This does not appear to be a "reassignment" nor does it appear to involve significant judgment as moving a floater employee around to meet the Employer's "production" needs has been found not to be supervisory authority. See *Hydro Conduit Corp.*, 254 NLRB 433, 438-39 (1981); *Hexacomb Corp.*, 313 NLRB 983 (1993); cf. *Wolverine World Wide*, 196 NLRB 410 (1972)(employee transfers from one job to another are supervisory when they are based on production determinations under the supervisor's sole discretion). See also *Franklin Home Health Agency*, supra at 830 ("Proof of independent judgment in the assignment of employees entails the submission of concrete evidence showing how assignment decisions are made. The assignment of tasks in accordance with an Employer's set practice, pattern, or parameters, or based on such obvious factors as whether an employee's workload is light, does not require a sufficient exercise of independent judgment to satisfy the statutory definition.")

The Employer contends that the RNs or their leads possess supervisory authority in sending employees home and calling in employees, as well as granting overtime. However, the evidence shows that this authority is limited to sending employees home if the providers to whom the employees are assigned leave the clinic early or if there is a drop in work. Call in authority is similarly limited to those situations when a provider to whom the called in employee is assigned shows up at the clinic or when replacing an absent employee. Significantly there is no authority to demand someone come in. Further, overtime is granted only for unavoidable situations. See *Print-O-Stat*, 247 NLRB 272 (1980) (authority to require overtime found by the Board not to be 2(11) supervisory authority where such authority is limited to only those times when tasks are not completed and deadlines are not met). In view of the above and the record as a whole, I find that the RNs do not exercise independent judgment with regard to sending employees home early or with regard to calling them in for work.

In sum, I find that the RNs and RN leads do not possess the authority to assign and/or to responsibly direct employees in their work. Indeed, I find it extremely implausible that HCAs could conceivably be immediately supervised by an MD, RN, RN lead, and by the Nursing Manager as argued by the Employer when it comes to the assignment and responsible direction of tasks. Nowhere in the record does the Employer detail how it would deal with the inevitable conflicts that would result from such an inexplicably high supervisory ratio. See *Harborside Healthcare*, above, and cases cited therein.

b.) <u>Hiring</u>

As was the case with the MDs, there was no evidence supporting the Nursing Manager's conclusory testimony that all hirings must be by consensus with her leads.

Instead, the evidence shows that the leads are supplied with preset questions that they are to ask of candidates. The RN leads merely offer their thoughts on the candidates and are not consulted again during the hiring process. Moreover, the recommendations have not always been unanimous before a decision on hiring was made and the decisions of the majority of the team have not always been effective. See *Third Coast Emergency Physicians*, above. Further, there is no showing what weight, if any, their opinions carried in the Employer's hiring decisions. See also *Acme Markets, Inc.*, 328 NLRB 1208, 1213 (1999) and *Children's Farm Home*, 324 NLRB 61, 65 (1997) (holding that participating in interviews, scoring applicants during interviews and making recommendations for hiring, through a hiring committee, did not cause the employee to fall within the definition of supervisor.) In light of the above and the record as a whole, I find that the RNs and their leads do not possess authority to hire or to effectively recommend the hiring of employees.

c.) <u>Evaluation</u>

The Employer argues that the evaluations, which RNs or their leads complete for other nurses, have a direct correlation to the rate of pay increase that the evaluated nurses receive. The Employer further argues that such authority establishes the RNs/leads statutory supervisory status and cites the following cases in support of that argument. *Beverly Health & Rehabilitation Services*, 335 NLRB 635 (2001); *Bayou Manner Health Center*, 331 NLRB 955 (1993); *Cape Cod Nursing Home*, 329 NLRB 233 (1999); *Hillhaven Kona Healthcare Center*, 323 NLRB 1171 (1977).

However, in all those cases, and others in that line such as *Trevilla of Golden Valley*, 330 NLRB 1377 (2000), the evaluator exercised control over the evaluated employees' rate of pay. The evaluator knew the numerical point value for each category up front, totaled the numbers, and determined the percentage pay for the evaluated employee. However, where an evaluating nurse did not know the numerical point values of the evaluated categories, had no input into those values during his or her evaluation, and where he/she did not know what the ultimate percentage increase would be resulting from his/her evaluation, the Board found such evaluations were not directly the result of the evaluator's judgment; thus, the evaluator's judgment in his or her evaluations did not establish the requisite independent judgment necessary to find 2(11) independent judgment. See *McAlester General Hospital*, 233 NLRB 589 (1977), overturned on other grounds, *IOOF Home of Ohio*, 322 NLRB 921 (1997).

As with the increases resulting from the nurses' evaluations in *McAlester*, the increases here are not directly the result of the evaluators' judgment. In particular, the RNs here, like the evaluators in *McAlester*, do not know the point values assigned to each category while they are completing the evaluations, have no input on what those values would be, or for that matter, have little or no input on the wording of the assessments which eventually lead to a change in an employees' rate of pay. Thus, it is clear that the RNs and RN leads merely provide information, which is eventually considered, weighted and analyzed by another process from which the RNs and RN leads are removed. Under these circumstances, the record reveals insufficient evidence to support a finding that the RNs or the RN leads possess supervisory authority as it relates to their respective roles in the evaluation process. See *McAlester,* 233 NLRB at 591.

d.) Discipline

The Employer claims that the RN leads possess the authority to discipline with regard to the issuance of informal and formal warnings. However, the record reveals that the only discipline levied in the Nursing Department relates to gossiping and tardiness. With the exception of tardiness, the record does not elaborate on what role, if any, the leads play in other types of discipline, including gossiping.

With respect to tardiness, the record, at the most, establishes that the RN leads monitor and report tardiness, and sign off on informal "verbal" warnings and on formal "verbal" and written warnings. However, the record does not elaborate much beyond the reportorial function served by the RNs leads with regard to tardiness. In particular, there is no evidence to support a finding that the RN leads make a recommendation of any sort to Mendez and/or whether such recommendations are regularly followed without independent investigation by Mendez or the Employer's HR department. However, the record does reveal that RN leads always consult with Mendez prior to the issuance of an informal or formal warning and that the particulars of each tardiness situation are discussed. The record does not elaborate further on the nature and extent of these consultations and/or discussions. In circumstances such as these, the Board has held that this type of reportorial authority does not establish supervisory status. See *Ken-Crest Services*, 335 NLRB 777, 778 (2001) (program managers were not supervisors, because their "limited role in the disciplinary process is nothing more than reportorial"); *Fleming Cos*., 330 NLRB 277 fn. 1 (1999) (supervisory status not found where employee communicated discipline only pursuant to management's directive; employee's role as a "mere conduit" for management was insufficient evidence of independent judgment); *Feralloy West Co*., 277 NLRB 1083, 1084 (1985) (employee who recorded employee attendance and brought employee records to management for a decision on whether to reprimand for attendance violations was not a supervisor).

The instant case is distinguishable from the Board's recent decision in *Progressive Transportation*, 340 NLRB No. 126 (2003). There, the disputed lead was found to possess authority to independently decide whether to bring rule infractions and misconduct -- not simply attendance violations -- to the manager's attention. When this disputed lead did decide to bring rule infractions to her manager, discipline normally ensued without an independent investigation.

Here, the record shows only that the RN leads are involved in discipline regarding tardiness, not the broad array of discipline that the lead in *Progressive Transportation* was involved in. With regard to tardiness alone, Mendez has made it clear that she wants the RN leads to bring all tardiness beyond a "minute here or there" to her attention -- this is hardly the degree of independent judgment possessed in *Progressive Transportation*. Moreover, the instant record fails to elaborate on whether the RN leads make effective recommendations without any independent investigation and whether discipline regularly ensues when tardiness issues are brought to Mendez. While Mendez testified that she delegated her authority to the leads last December when she went on vacation and that discipline was issued during that vacation by an RN lead, the Board has held that the sporadic exercise of supervisory authority is not sufficient to transform an employee into a supervisor. *Acme Markets,* above at 1213; *Robert Greenspan*, *DDS, P.C.*, 318 NLRB 70, 76 (1995) enfd. 101 F.3d 107 (2d Cir.), cert. denied 519 U.S. 817 (1996).

In light of the above and the sparse record in this regard, I find that the RN leads do not possess supervisory authority to discipline employees or to effectively recommend the same.

IV.) CONCLUSION

In view of the record evidence, I shall direct an election in the following appropriate Unit:

> All regular full-time, part-time and per diem[33] professional positions, including medical doctors, clinical leads and/or clinical chairs, registered nurses, registered nurse leads, physician assistants, nurse practitioners, nurse midwifes, behavioral health specialists, registered dietitians and the Kennewick Lead, employed at the Employer's Kennewick Medical facility located at 5219 West Clearwater, Suite No. 6, Kennewick, Washington, and employed at the Employer's Pasco Medical facility located at 525 West Court Street, Pasco, Washington; excluding all other employees, managers, guards and supervisors as defined in the Act.

There are approximately 42 employees in the Unit found appropriate.

V.) DIRECTION OF ELECTION

An election by secret ballot shall be conducted by the undersigned among the employees in the Unit found appropriate at the time and place set forth in the notice of election to be issued subsequently, subject to the Board's Rules and Regulations. Eligible to vote are those in the Unit who were employed during the payroll period ending immediately preceding the date of this Decision, including employees who did not work during that period because they were ill, on vacation, or temporarily laid off. Employees engaged in any economic strike, who have retained their status as strikers and who have not been permanently replaced are also eligible to vote. In addition, in an economic strike, which commenced less than 12 months before the election date, employees engaged in such strike who have retained their status as strikers but who have been permanently replaced, as well as their replacements are eligible to vote. Those in the military services of the United States may vote if they appear in person at the polls. Ineligible to vote are employees who have quit or been discharged for cause since the designated payroll period, employees engaged in a strike who have been discharged for cause since the commencement thereof and who have not been rehired or reinstated before the election date, and employees engaged in an economic strike which commenced more than 12 months before the election date and who have been permanently replaced. Those eligible shall vote whether or not they desire to be represented for collective bargaining purposes by United Staff Nurses Union, UFCW Local 141, United Food & Commercial Workers International Union, AFL-CIO.

A.) List of Voters

In order to assure that all eligible voters may have the opportunity to be informed of the issues in the exercise of their statutory right to vote, all parties to the election should have access to a list of voters and their addresses that may be used to communicate with them. *Excelsior Underwear*, 156 NLRB 1236 (1966); *NLRB v.*

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[33] The parties stipulated to the inclusion of the professional per diems in the Unit.

Wyman-Gordon Co., 394 U.S. 759 (1969). Accordingly, it is hereby directed that an election eligibility list, containing the alphabetized full names and addresses of all the eligible voters, must be filed by the Employer with the Regional Director for Region 19 within 7 days of the date of this Decision and Direction of Election. *North Macon Health Care Facility*, 315 NLRB 359, 361 (1994). The list must be of sufficiently large type to be clearly legible. The Region shall, in turn, make the list available to all parties to the election.

In order to be timely filed, such list must be received in the Regional Office, 915 Second Avenue, 29th Floor, Seattle, Washington 98174, on or before November 5, 2004**.** No extension of time to file this list may be granted except in extraordinary circumstances, nor shall the filing of a request for review operate to stay the filing of such list. Failure to comply with this requirement shall be grounds for setting aside the election whenever proper objections are filed. The list may be submitted by facsimile transmission to (206) 220-6305. Since the list is to be made available to all parties to the election, please furnish a total of 4 copies, unless the list is submitted by facsimile, in which case only one copy need be submitted.

B.) Notice of Posting Obligations

According to Section 103.20 of the Board's Rules and Regulations, the Employer must post the Notices to Election provided by the Board in areas conspicuous to potential voters for a minimum of 3 working days prior to the date of the election. Failure to follow the posting requirement may result in additional litigation if proper objections to the election are filed. Section 103.20(c) requires an employer to notify the Board at least 5 full working days prior to 12:01 a.m. of the day of the election if it has not received copies of the election notice. *Club Demonstration Services*, 317 NLRB 349 (1995). Failure to do so estops employers from filing objections based on nonposting of the election notice.

C.) Right to Request Review

Under the provisions of Section 102.67 of the Board's Rules and Regulations, a request for review of this Decision may be filed with the National Labor Relations Board, addressed to the Executive Secretary, 1099 14th Street, N.W., Washington, D.C. 20570-0001. This request must be received by the Board in Washington, D.C. by 5 p.m., EST on November 12, 2004**.** The request may **not** be filed by facsimile.

DATED at Seattle, Washington this 29th day of October 2004.

/s/ Richard L. Ahearn

Richard L. Ahearn, Regional Director
National Labor Relations Board, Region 19
2948 Jackson Federal Building
915 Second Avenue
Seattle, WA 98174